

**Tennessee Department of Safety
Driver Improvement Section
1150 Foster Ave.
Nashville TN 37210**

MEDICAL REPORT

I hereby authorize Dr. _____ to give me any examination he deems necessary for the purpose of determining my fitness to operate a motor vehicle. I also authorize the Department of Safety to have this information reviewed by a consulting board of unidentified physicians for the purpose of giving the department a medical evaluation on my case and that this information will be identified by number only to the consulting physicians. I understand that the department is in no way responsible for any expense that arises from this examination.

Signature of patient

Date

This report must be completed by a licensed physician, in addition to any hospital, medical or VA records that you wish to make part of your medical history with this department. This examination must have been performed within the twelve (12) months.

Name _____ Date of Birth _____

Address _____ Case Number _____

Driver License# _____

Patients Medical History

(PLEASE TYPE OR PRINT LEGIBLY)

Does the patient have any physical or mental impairments? Yes _____ No _____ If yes, explain _____

Does the patient use any drugs/medicine regularly? Yes _____ No _____. If yes, explain _____

To your knowledge is medication taken as prescribed? Yes _____ No _____. If no, explain _____

Does Patient drink alcoholic beverages? Yes _____ No _____. If yes, to what extent? _____

What effect would alcohol and patient's medication have on patient? _____

Is there any parkinson's disease? Yes _____ No _____. Is coordination normal? Yes _____ No _____. Is there any vertigo? Yes _____ No _____. Is there any disease present which would effect the nervous system and/or the motor senses (coordination)? Yes _____ No _____. If yes, explain _____

Is this condition being treated? Yes _____ No _____. If yes, explain _____

List names of physicians with their field of medicine that have treated this patient in the last two years.

Physicians name

Field of medicine

CARDIAC Functional Capacity (AHA)

Class 1 No limitation physical activity _____

Class 2 Slight limitation physical activity _____

Class 3 Marked limitation physical activity _____

Class 4 Complete limitation physical activity _____

Blood pressure _____ Edema _____

Dyspnea and/or Angina: At rest _____

Slight exertion _____

Moderate _____

Is There any syncope? _____ If Yes, frequency and severity _____

Does the patient take Nitroglycerin or blood pressure medicine? Yes _____ No _____. If yes, daily dosage? _____

DIABETIC Yes _____ No _____ If yes, please complete questions below.

Age of onset _____ Does patient take insulin? Yes _____ No _____. If Yes how much? _____

What type of insulin is taken? _____.

Has patient ever been in coma? _____ How Many times? _____ Date of last coma _____.

Has patient ever had insulin shock? Yes _____ No _____ How many times? _____

Date of last insulin shock? _____. Is there any warning of impending coma or shock? _____

Urine Analysis _____ S.P.G.R. _____

Albumin _____ Sugar _____ Micro _____

ORTHOPEDIC Yes _____ No _____ If yes, please complete questions below.

Are there any stiff or flail joints? Yes _____ No _____. If yes, where? _____

Have there been any amputations? Yes _____ No _____. If yes, where? _____

Are there any spastic or paralyzed muscles? Yes _____ No _____. If yes, where? _____

Does patient need orthopedic appliances or supports? Yes _____ No _____ If yes, where? _____

Do any of the above interfere with the patient's driving? Yes _____ No _____. If yes, to what extent? _____

HEARING Conversational voice-distance in feet _____ Audiometric test if indicated _____

Is hearing aid worn? Yes _____ No _____. If yes, does it give sufficient correction? Yes _____ NO _____.

VISUAL Visual acuity- Name type of equipment used _____

Without Glasses RE 20/_____ LE 20/_____ BE 20/_____

With glasses RE 20/_____ LE 20/_____ BE 20/_____

Field of vision _____ Color vision _____

Coordination _____ Depth perception _____

IF ANY OF THE FOLLOWING APPLIES TO PATIENT, HE/SHE MUST HAVE THEIR PERSONAL EYE DOCTOR COMPLETE THIS PORTION OF THE MEDICAL REPORT.

Is there any disease that would contribute to the loss of sight or impair the patient's ability to operate a motor vehicle? (cataracts, glaucoma, etc.)_____ Has this condition been treated by surgery Yes_____ No_____. If yes, what were the results_____

Is there any retina detachment, etc. present at this time? Yes_____ No_____ If Yes explain_____

Is patient diabetic? Yes_____ No_____ If yes, what effect does it have on the eyes. If any_____

What is the best possible vision if any of the above applies? RE20/_____ LE20/_____ BE20/_____

PSYCHOLOGY (To be completed by psychologist, if applies)

What was the highest grade completed in school? _____ At what age was it obtained? _____

Has patient ever been institutionalized or treated in a hospital for mental illness? Yes_____ No_____. If yes, when _____ History _____

Was patient restored to competency? Yes_____ No_____ If yes, by what authority?_____

Is patient on medication? Yes_____ No_____ If yes, what kind?_____

Dosage?_____. What effect, if any does the medication have on patients ability to operate a motor vehicle?_____

Has patient ever been committed to a hospital for alcohol or drug treatment? Yes_____ No_____. If yes, explain _____ Dates _____

Location_____ How many times?_____ Length of stay_____

What type of discharge did patient receive?_____ Was medication prescribed at time of release? Yes_____ No_____ If yes, what kind of medication_____

_____ Dosage_____

To your knowledge has patient used drugs or alcohol in excess since his release from the hospital?_____

In your opinion should this person be permitted to drive? Yes_____ No_____ If no, please explain_____

PLEASE LIST OTHER SIGNIFICANT FINDINGS WHICH IN YOUR OPINION WOULD INHIBIT THE INDIVIDUAL'S ABILITY TO OPERATE A MOTOR VEHICLE SAFELY. _____

NEUROLOGICAL

Has this patient ever had a seizure? Yes_____ No_____. Loss of consciousness? Yes_____ No_____

If yes to the above give dates_____ If yes to the above give dates_____

What caused seizure or loss of consciousness?_____

Age of first seizure?_____ Type(s) Major motor_____ Minor Lapses_____ Other_____

Describe_____

Have any spells occurred when patient is awake? Yes_____ No_____ Medication patient was taking at the time of last seizure_____

Date of last seizure_____ Medication patient is presently_____
_____ Do you think the patient takes medication regularly? Yes_____ No_____

When did you last check patient's serum anticonvulsant levels?_____

How long have you treated this patient for this condition?_____

EXAMINING PHYSICIAN

How long you have you treated this patient?_____

Date you last examined or treated this patient?_____

Date questionnaire completed?_____

NOTE: The Department of Safety requires, before an individuals driving privileges be reinstated, a six-month period of time lapse without the occurrence of the following conditions: Seizure, blackout, insulin shock, coma or any condition whereas control of physical motor movements are lost.

FOR THIS MEDICAL REPORT TO BE CONSIDERED, THE NEXT QUESTION MUST BE ANSWERED.

IN YOUR PROFESSIONAL OPINION IS THIS PATIENT MEDICALLY AND MENTALLY CAPABLE OF OPERATING A MOTOR VEHICLE SAFELY? YES_____ NO_____

NAME OF PHYSICIAN (PLEASE PRINT)

DATE

I.D. NUMBER

SIGNATURE OF PHYSICIAN

PHONE NUMBER

ADDRESS

CITY

STATE

ZIP

The Department of Safety is in no way responsible for any expenses that may result from this examination.